TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
STEVE SACKS, MD

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-13-0397

Carrier's Austin Representative
Box Number 45

MFDR Date Received
OCTOBER 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position summary was not submitted for review.

Amount in Dispute: $194.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On 7/9/2012 the Office received a bill for Designated Doctor referred testing of a NCV/EMG study; an audit was performed and reimbursed $1,149.36 for CPT codes 95900 and 95904. The audit denied CPT code 99203 for medical necessity utilizing ANSI code 50 and T-13, as the injured employee was referred to Dr. Sacks for testing only, and found that an evaluation and management services was neither requested nor necessary…an audit was performed which allowed an additional reimbursement for CPT code 95886 in the amount of $565.16."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2012	CPT Code 99203 Office Visit	$169.61	$0.00
	HCPCS Code A4556 Electrodes	$25.00	$0.00
TOTAL		$194.61	$0.00

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 50-These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - T13-Medical necessity denial.
   - 97-The benefit for this service is included in the pymt/allowance for another service/procedure that has

already been adjucated.

Issues

1. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity? Are the disputed services eligible for review by Medical Fee Dispute Resolution?
2. Is the benefit for HCPCS code A4556 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement for HCPCS code A4556?

Findings

1. The medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for the same service(s) for which there is a medical fee dispute. Review of the EOBs presented by the both the requestor and respondent indicate denial reason code "50" and "T13" were used to deny reimbursement for CPT code 99203.

   Resolution of a Medical Necessity Dispute. The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***

   Notice of Dispute Sequence. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.

   The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

   The division finds that due to the unresolved medical necessity issues, the medical fee dispute request for code 99203 is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

2. According to the explanation of benefits, the respondent denied reimbursement for HCPCS code A4556 based upon reason code "97".

   HCPCS Code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."

   Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4556. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/09/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.